**Statement of Deborah Steelman, Esq.**

Medicare is the single most important contribution to seniors' health care ever enacted. Because of Medicare, every senior has basic health insurance. But Medicare has not kept pace with modem medicine and the needs of seniors. The Breaux-Frist proposal would transform Medicare into the program it should be, with choices for outpatient prescription drug coverage and stop-loss protection, without disrupting the coverage seniors and their families now rely upon.

Health care has changed dramatically since Medicare was created. In 1965, long hospital stays and confinements in nursing homes were common. People were either treated in a doctor's office or in the hospital. Today, thanks to medical research, hundreds of breakthrough medicines are available allowing people to live longer and healthier lives, especially seniors. Advances in medical treatments mean that more people can be treated at home or in outpatient settings, and with a combination of services like home care, therapy and drugs.

Yet, as this committee is well aware, Medicare's benefit package has not kept pace with modem medicine or the quality of coverage available to the average working citizen today. For example, coverage for outpatient prescription drugs and a cap on out-of-pocket expenses have been standard features for many years in private health plans, including those sponsored by the federal government as an employer.

To compensate for the anachronistic nature of Medicare's benefit package, the private sector has responded in both the employer and individual insurance markets. Many employers offer retiree benefits that include outpatient prescription drugs. Individual options include comprehensive health plans in the Medicare+Choice program and a supplemental insurance market. Over 12 million seniors obtain "wraparound" coverage through retiree benefit programs, and another 10 million purchase individual insurance plans.

The federal government's most recent attempt to significantly modify Medicare's benefit package, the Medicare Catastrophic Coverage Act, was repealed ten years ago. Its repeal was due largely to opposition from seniors who had paid for retiree benefits in their working years and found themselves faced with significant premium liabilities under the new law. Since then, the federal focus has been on incremental improvements to Medicare's benefit package, improving the options for comprehensive coverage through the Medicare+Choice program, and ensuring a comprehensive set of benefits to the poorest seniors through Medicaid.

In the decade since the repeal of the Medicare Catastrophic Coverage Act, many state governments have created special state assistance programs just for pharmaceutical therapy. Currently 16 states offer 19 such programs, covering approximately 935,000 seniors. Income eligibility varies from state to state, ranging from about $9,000 in Maryland to about $23,000 in Pennsylvania and New York for individuals.

Nevertheless, too many elderly Americans can't get the medicines they need because they cannot afford the private sector coverage that is available, and their resources are too great to qualify for Medicaid or their own state's assistance program.

The inadequate coverage of the Medicare program forces beneficiaries to piece together coverage from multiple sources. Bob Reischauer, former CBO director and current senior fellow at the Brookings Institution, refers to this piecemeal system of acquiring coverage as the "hybrid system." This system is inherently inefficient.

This inefficiency is more serious than may be apparent upon initial review. The Health Care Financing Administration (HCFA) is often credited with disbursing 98 cents on the dollar in benefits. This two-percent administrative cost would be a great source of pride were it not so penny wise and pound foolish. This year, for example, the agency received significant kudos for reducing waste to a mere $12.6 billion dollars. This only proves how low our standards are for a program in which the highest standards should be demanded. For example, twelve billion dollars a year would be enough to fund a modest prescription drug benefit

How did Medicare get to the point where $12 billion in unaccountable expenditures is considered an improvement? The program's complexity, internal inconsistencies, and multi-layered governance structure provide some clues.

Last year the Mayo Clinic estimated that Medicare contained over 132,000 pages of regulation, manual instruction, fraud and abuse guidelines and other federal directives. How much time and talent is consumed by an organization as respected and as well run as the Mayo Clinic to comply with this blizzard of paperwork? How do many smaller hospitals and physicians offices keep up? And how much true criminal fraud is invited by a system where the clever can so easily manipulate complexity for their own personal gain?

Taxpayers are not the only ones who pay for the inefficiency of the hybrid system. Beneficiaries pay. The most common complaints from seniors are due to the lack of appropriate coordination of benefits between the federal and private sector components of seniors' three-part benefit package; Part A, Part B, and their supplemental coverage. While one carrier decides it is another carriers' responsibility to pay and that carrier decides it is the other carrier's responsibility to pay, seniors are left with confusion and unpaid bills. Or bills get paid twice and a senior calls their doctor's office or the hotline, reporting it, only to be told the amount is too small to worry about.

Any reform of Medicare that does not take into account the entirety of this "hybrid" system will doom seniors and taxpayers to the higher costs of such inefficiency.

Stan Hinton, a retired newspaper reporter who writes of the practical side of retirement for the Washington Post wrote a common sense list of Medicare improvements he and his wife wanted. He wrote, "We want to feel that if we get ill we can depend on Medicare's contractors to handle our claims quickly, efficiently and without a lot of confusion over what Medicare will pay for ... We want to stop getting those mysterious 'Explanation of Benefits' notices that don't really explain anything. want to get a letter from Medicare once a year telling us which contractors are handling our doctors' and hospital claims, where their offices are located and their phone numbers ... We want Medicare, once it reviews and pays one of our claims, to send it electronically to our Medigap policy company. That would help end some of the payment delays." The list continued.

One of the best ways to reduce the confusion is to offer seniors the option of a single comprehensive benefit plan. This is also the best way to provide seniors the kind of benefits that have become so commonplace for workers all across America. Surely it cannot be too difficult for the Congress and the President to agree that all seniors should have the same kind of health plan choices that they have themselves.

From all sides of the political and academic spectrum, there is agreement on the need for a new model. Before the Medicare Commission, witnesses from Heritage Foundation, the Urban Institute, and a variety of universities urged the adoption of some system based on better pricing and better choices. Bob Reischauer testified that "[He did] not think there is any way to address these deficiencies within the

current system and so the question is whether there is some different structure that might address these deficiencies."

This was the conclusion of at least 12 of the 17 members of the National Bipartisan Commission on the Future of Medicare. While only ten of us voted for the Commission's final product, it was not due to lack of the required super-majority consensus on this point. Two of the President's appointees to the commission, Laura Tyson and Stuart Altman, said in the Washington Post on March 29, 1999 "We have long supported the idea of market competition to encourage efficiency in health care, so we are sympathetic to the premium support approach."

Why would a super-majority of the Medicare Commission - 8 Republicans and 4 Democrats - and a host of witnesses across the political spectrum all embrace market competition as the direction in which Medicare must turn? I believe it is because the lessons of price controls have been well learned in this country and abroad.

We are all familiar with the waiting line and care denial stories that emanate from other countries. A recent poll found that 75% of Canadians, citing declines in service, now believe their health system is in crisis (Washington Post, 12-18-99). The same article described myriad examples of unavailable and postponed treatments. This is the inevitable result of price controls.

The Breaux-Frist proposal adapts the principles embodied in the Federal Employee Health Benefits Program (FEHBP) to the special needs of seniors and disabled beneficiaries, and to the political, policy, and budgetary challenges that accompany any serious attempt to modify the Medicare program.

The FEHBP, a form of premium support, has served millions of employees and retirees for over 30 years. Employees in every region of the country have numerous choices of comprehensive benefit packages, and benefits are routinely updated to reflect continuing advances in medical technology and improvements in quality of care. Plans have an incentive to offer the most attractive options for beneficiaries at a reasonable cost. Beneficiaries routinely pay about 25% of the premium and their employer, the federal government, pays the rest. Perhaps because beneficiaries have a stable partner in paying their premiums, many federal employees and retirees have chosen fee-for-service plans. Seventy percent of enrollees are in BlueCross/ BlueShield or other fee-for-service plans. The remaining thirty percent are in HMOs.

The question for the Commission was how to preserve the best of Medicare while incorporating the best of FEHBP?

**Guarantee Benefits.** Federal employee benefits are delivered year in and year out without arbitrary budgeting by Congress or micromanagement by government.

The first priority of Medicare reform must be to increase the confidence level beneficiaries have in the benefits of the program. This is true not only for today's seniors, but also for those who retire over the coming decades. The biggest fear younger generations have for Social Security is that it will not "be there" when they retire. The biggest fear younger generations have with Medicare is the illusion its benefit package is becoming.

The notion that the Medicare entitlement is secure today is Just plain wrong. In fact, as AARP's political ads have pointed out for much of the last two decades, the largest threat to the security of Medicare's entitlement is the relentless and relatively arbitrary budgeting reductions routinely taken by Congress and the Administration. While some applaud the latest CBO's forecasted HI Trust Fund surplus, it

should be noted that this estimate results from little more than the program underspending the original Congressional estimates by $63 billion. HCFA cannot say why this is happening, and has yet to say how many beneficiaries and providers are being harmed.

Medicare's price controls squeeze benefits. How does a Medicare+Choice enrollee feel when they see their benefits diminish or their health plan leave a market because payment is too low? How secure does a beneficiary feel when Medicare will not allow coverage for multiple procedures performed in the same day? How secure does a transplant patient feel when Medicare's coverage for their immunosuppressant drugs runs out?

These problems would be exacerbated by adding drug coverage to the current Medicare program. More and more of our health care dollar will be devoted to prescription medicines. This is a good thing. Outpatient drugs are the least invasive, least dangerous, most convenient way to treat illness. More and more conditions and diseases of the elderly will be eased or cured by prescription drugs. Yet the cost of paying for these medicines entirely by tax collections would put sufficient pressure on the whole program to make the cost containment measures of the '80's and '90's pale by comparison.

There are some who support price controls either as a way of reducing the cost of drug coverage or as a way of reducing costs for seniors who may or may not have drug coverage. We have only to look at recent experience in Medicare to understand the disruptions caused by prices set in Washington. When the HI Trust Fund underspends last year's estimates by $63 billion, there are consequences.

These are things no federal employee has to worry about. And yet, the FEHBP has a slower growth rate than Medicare over the same time period, by over a full percentage point.

This seems a good lesson to draw upon in terms of making Medicare's benefits more secure, while at the same time making the program more efficient and cost less.

If our priority is to make benefits predictable and stable from year to year, yet flexible enough to improve over time, prices must vary. In the current Medicare+Choice program, the government administers prices; no wonder benefits vary.

As Professors Feldman and Dowd testified before the Medicare Commission, HCFA [the agency which runs Medicare] never learns the true cost of providing health care in an efficient system." Under the Breaux-Frist plan, in contrast, plans would determine the premiums and plan designs under oversight of The Medicare Board. This encourages plans to offer the most attractive benefit packages at the most affordable rates.

**Guarantee Level of Premium Sharing** Today seniors pay about 33 percent of their total medical care costs, even though they pay only about 12 percent of their Medicare costs which is deducted from their Social Security checks as the Part B premium, currently $45.50 per month. The Breaux-Frist proposal maintains this same share of beneficiary-to-taxpayer premium sharing.

Like the FEHBP, the federal government would guarantee a certain percent of the total plan premium, allowing beneficiaries to pay a lower premium if they choose a less costly plan and pay more if they choose a high option, or more costly plan. As in FEHBP, the premiums for all health plans would be set by the plans in the marketplace. Experience suggests that running the Medicare program this way would save between one and one and one-half percentage points per year.

Beneficiaries are good shoppers, much better than those in Congress and the bureaucracy at HCFA. As

Len Nichols of the Urban Institute said at one of the Commission's early hearings, "it is very difficult to get 10,000 prices right in each of 3,000 counties." Government's role is much better suited to consumer protection than price regulation.

The Breaux-Frist proposal focuses the power of government on what it has shown it can do well in FEHBP: overseeing plans, and not micromanaging prices. Seniors should be able to rely on a guaranteed level of benefits and payments, making their benefits secure and their premium obligations predictable and controllable.

**Provide Full Choice of Plans and Comprehensive Benefit Packages.** In assessing the differing needs of Medicare beneficiaries and employees enrolled in FEHBP plans, one of the biggest differences had to address was the supplemental insurance many seniors already have. Federal employees get all their insurance from one source; Medicare beneficiaries do not.

The Breaux-Frist proposal resolves this difference by requiring all plan sponsors, whether the federal government or private plans, to offer both a standard option plan and a high option plan.

The standard option would cover the same services as provided through Medicare today, allowing seniors to keep their supplemental insurance if they chose. Seniors must have the option of keeping what they have not only in terms of the existing Medicare program, but also the existing supplemental coverage, whether that coverage is employer-sponsored, individually purchased, or available through Medicaid or other state assistance.

The Breaux-Frist proposal requires all plan sponsors to offer a high option plan that would add coverage for outpatient prescription drugs and a cap on out-of-pocket expenses to the current Medicare benefits, and would pay 25% of the additional premium for any senior who elected a comprehensive plan. This would allow all seniors no matter where they live, to comparison shop and to apply any or all of the resources they may have, including employer contributions or state Medicaid or assistance plan funds, to the purchase of a single, comprehensive health plan of their choice. Amazingly, this simple form of health insurance, the comprehensive health plan, has never been an option in Medicare.

Clearly, a high option comprehensive plan will be much less expensive than purchasing the equivalent coverage through the multi-part "hybrid" system of supplemental+A+B+out-of-pocket. In testimony to the Medicare Commission Reischauer stated, We provide Medicare, or health benefits to the elderly right now in an inefficient way. And ... they are paying a lot out-of-pocket. By restructuring the program and consolidating the insurance into one insurance rather than into multiple insurances, you can provide at least those same benefits at less cost." This is the reason I believe the top priority for any reform must be to provide a predictable, reliable,, comprehensive benefit package for seniors, no matter where they live or their level of income.

In the area of taxpayer dollars to support the drug benefit, the Breaux-Frist proposal goes a step further than the Medicare Commission report. By paying 25% of the premium associated with drug coverage, their proposal will reduce adverse selection and will appeal to the economic interests of all seniors. By requiring health plans to offer comprehensive coverage, including outpatient prescription drugs, plenty of coverage options will be available. Drug coverage in such integrated plans should cost no more than $700-900 per year. That is significantly less than the annual median cost of $2,400 for Medigap plan "J," which includes limited drug coverage. Second, the Breaux-Frist proposal pays the full cost of a comprehensive health plan for all beneficiaries of low and modest means who cannot afford their share of the premium. Third, The Breaux-Frist proposal guarantees today's Medicare benefits at today's taxpayer-beneficiary share of the premium, with the promise of improved efficiency to lower the

beneficiaries' premium and the taxpayers' obligation.

**Create Room for Innovation.** How would beneficiaries gain if the Medicare "reform" locks the new benefit designs in the same concrete sinking the Medicare benefit package today? Health plans must have a certain flexibility to offer new benefits and services that reflect medical advances and quality improvements giving seniors access to the latest medical treatments.

Again, adopting a FEHBP approach makes senses. The federal program allows plans to talk with enrollees and to do the market research to determine what plan design and innovation in coverage is desired. The Office of Personnel Management oversees the process to ensure against excessive premium increases, unfair competition or intentionally risk averse plan designs, allowing benefit offerings that do not exceed a 10% increase in the actuarial value of the standard package

**Guarantee Access to High Option Plans Regardless of Ability to Pay.**

Other differences between federal enrollees and Medicare beneficiaries include the disparity in income levels and health status.

To enable comprehensive coverage through high option plans, the federal government should cover the entire cost of premiums (but not all deductibles and copays) for seniors whose annual incomes are less than $10,500.

To guarantee access to health plans for people with serious illness and to ensure against intentional risk selection, Medicare health plans must receive payments that differ according to the health care needs of the patient. I believe a system that required health plan participation in reinsurance, or one that isolates the costs of high cost care, would be more effective than a characterization of individuals health status or statistical compilation of plan usage.

**Stabilize Medicare Financing.** By introducing competition and choice into the Medicare program, we can slow the rate at which the program's costs rise and preserve it for generations to come.

Competition between plans encourages them to offer quality services at an affordable price. And by linking the government's contribution to the average cost plan, the proposal encourages beneficiaries to select more efficient plans, further keeping down costs.

According to the Congressional Budget Office, HCFA and independent sources, the competition and choice inherent in Breaux-Frist can keep costs down and stem the long-term growth rate of the Medicare program. Estimates indicate Medicare's growth rate would decrease from between one and one and one-half percentage points per year.

But even the Breaux-Frist proponents recognize the difficulty of predicting health care costs over the long term, whether in public or private health spending, regardless of what program is in place. No one can predict with certainty how much this reform, or any other, would reduce Medicare's spending.

At the Commission's first meeting, Alan Greenspan cited the impact of technology as just one of the more unpredictable obstacles to long term estimates, saying that he ". . could allude to all sorts of forecasts over the most recent generations--one of the largest difficulties is in forecasting the pattern of technology. It is an extremely difficult activity." That is just one reason why "long-term solvency" is not the primary reason to enact reform today. There are far more important reasons to enact reform than the "exercises in comparative fantasy," as Bruce Vladeck describes all long-term estimates.

Beneficiaries' health and health care are the primary reasons to reform Medicare and to do it now.

New drugs are at the heart of our hope for long and healthy lives. It is unthinkable that there is no comprehensive and predictable way for all seniors to have drug coverage today. Yet we cannot avoid the possibility that including prescription drugs in the benefit package will bring with it costs that would absorb any savings our reform might achieve as well as add additional, and likely, intolerable taxpayer burdens to future generations.

Along with every other parent of children under the age of 30, I care very much about my children and their fate of becoming the taxpayers supporting millions of baby boomer retirees. My children will be 26 the year I retire. They will be in a first or second job; they will be trying to buy their own health care, a first home, paying the costs of raising children. They will not have had a lifetime to build up assets. And there will be fewer of them in relation to us retirees. Their burden will already be great. So I want to reduce the tax burden for them; I want to do all I can to make the shared responsibilities of future taxpayers and future beneficiaries fair.

To ensure that this debate is more open than the one occurring today -- creating Part A "solvency" through general fund transfers of one kind or another -- the Breaux-Frist proposal would create a new concept of solvency. Because beneficiary premiums and the payroll tax rate can only be amended by law, and have proved very difficult to modify over time, the only meaningful solvency test is one based on the amount of general revenues required to make up the difference.

In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare program outlays, the Trustees should be required to notify the Congress that the Medicare program is in danger of becoming insolvent. Congress would be required to legislate alternative funding or to increase the level of general revenues dedicated to the program. This new measure of Medicare solvency would clearly illuminate the ratio of relative financing burdens on general revenues, the Hospital Insurance payroll tax, and the premiums beneficiaries pay, and would require a public dialogue to determine the fairest financing burden between beneficiaries and younger taxpayers.

**The Time Is Now.** Mr. Chairman, I believe that by the time I retire we will have a system that looks much like the Beaux-Frist plan. It combines the best of the marketplace and government -- innovative and efficient health care, a guaranteed benefits for seniors, and equitable financing obligations for beneficiaries and younger taxpayers, which ensures quality care at a reasonable price.

Seniors will never be totally secure about their Medicare program until the Medicare program is taken out of the arbitrary, budget-driven and, bureaucratic process and responds to people's needs more than government's.